NAVIGANT

PAYMENT REFORM IN OREGON AND MINNESOTA

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MINNESOTA: ACCOUNTABLE HEALTH MODEL – MEDICAID SHARED SAVINGS AND RISK ARRANGEMENTS

MINNESOTA STATE INNOVATION MODEL (SIM)

- Purpose of the Demonstration
  - Develop and implement a demonstration testing alternative and innovative health care delivery systems, including accountable care organizations (ACOs)
  - Align the measures and incentives for this program with other state initiatives
  - Uses accountable health care model
    - Started **Integrated Health Partnerships** (IHPs) with a $45 million grant for Medicaid ACO model development
- What is an IHP?
  - Expands patient-centered, team-based care through service delivery and payment models that support integration of medical care, behavioral health, long-term care and community prevention services
  - IHPs adopt ACO-style contracts with providers to better coordinate care, sharing both savings and risk, and measuring cost and quality against predetermined benchmarks
  - Under SIM, IHP providers must demonstrate partnerships with community supports

ASSUMING RISK AND PAYMENT FOR CCO SERVICES

- IHPs have two tracks for payment and risk assumption
  - **Virtual IHPs: Upside only (only share in savings, not losses)**
    - Not formally affiliated with a hospital or integrated system through financial arrangements or information systems
    - Serve between 1,000 and 1,999 attributed members
    - Years 1-3: Gain-sharing only, savings between the payer(s) and delivery system is shared equally (i.e., 50/50)
  - **Integrated IHPs: Upside/Downside (share in savings & assume risk for losses)**
    - Provide outpatient and inpatient care and serve at least 2,000 attributed members
    - Phase-in risk over three-years:
      - Upside risk only in the first year
      - Share in upside savings and responsible for downside risk equivalent to half of the upside risk potential in the second year (some flexibility in assumed risk)
      - Symmetrical savings and risk sharing in the third year

QUANTITATIVE MEASURES AND SHARED SAVINGS

- Minnesota tracks IHP performance on:
  - 32 clinical quality and patient experience measures, scored and weighted as 9 measures after measure aggregation
    - All measures are reported in year one, then increasingly tied to payment
    - IHPs are encouraged to propose additional measures tailored to the specific communities and populations served by the IHP

- Shared Savings based off metrics are phased in over three years:
  - Year one, 25 percent of IHP portion of shared savings are based on reporting quality metrics
  - Year two, 25 percent of IHP portion of savings are based on performance improvements
  - Year three, 50 percent of IHP portion of savings are based on performance improvements

HOUSING LINKAGES

- Minnesota requires that Medicaid ACOs coordinate medical and social services with social service agencies and community-based organizations
  - Hennepin Health ACO is an "MCO/provider hybrid ACO" employing social workers & housing counselors to help members address their housing needs as a part of their health risk factors
    - Primary care clinic-based care coordination teams identify that a medically complex / frequently hospitalized member is homeless or precariously housed
    - Housing / social service navigators play a broker role in assessing and matching members to available housing, working as part of the clinic / hospital teams
    - Shared savings are reinvested to fund transitional public housing for members
  - Funded through capitated Medicaid payments & other sources (for social services)
    - After the first year, Hennepin Health could pay salaries of housing navigators using the health care savings from spending less than the capitated payments
    - County housing providers are encouraged to give priority to people who are referred by Hennepin Health housing navigators

RESULTS AND FINDINGS

- Results
  - Minnesota's IHP program saved the state $76.3 million over its first two years ($14.8M in the first year and $61.5M in the second year)
  - All nine IHPs, including an FQHC-led IHP, achieved shared savings in year two and exceeded their quality targets
  - The 2014 results significantly improve upon the savings from the project's first year in 2013, which were also higher than originally projected
- Findings
  - Due to diversity in approaches and strategies for implementing IHPs, the State has to work with providers in examining eligibility and infrastructure for assuming risk
  - Minnesota has added caps on upside savings when providers cannot or do not take on downside risk
  - Vermont and Maine are looking to Minnesota's model to deliver cost-savings for their programs

OREGON: STATEWIDE COORDINATED CARE ORGANIZATION (CCO) PROGRAM

OREGON SECTION 1115 DEMONSTRATION AND SIM

- Purpose of the Demonstration
  - To redesign Medicaid delivery using Coordinated Care Organizations (CCOs) as a single point of accountability for access, quality, and outcomes
    - CMS provided $1.9 for CCO development via Designated State Health Programs
  - Oregon's SIM grant of $45 million over 3 ½ years helps support the CCO model by:
    - Providing resources and technical assistance to CCOs via the Oregon Transformation Center
    - Evaluating methods of integration and coordination within CCOs
    - Testing new payment models, including CCOs' global budgets and value-based alternative payment models
  - Oregon's Transformation Center supports CCOs through technical assistance and data analytics, rapid evaluation, learning collaboratives and dissemination of best practices across CCOs
  - Potential savings of $3 billion over 5 yrs resulting from CCO care delivery efficiencies

OREGON MODEL KEY COMPONENTS

- Separately, these elements all assist in producing better health outcomes at lower prices
- When all elements are used to together, they are the most effective in achieving better health, better care and lower costs

COORDINATED CARE ORGANIZATIONS (CCO)

- What is a CCO?
  - A coordinated care organization is a network of all types of health care providers (physical health care, addictions and mental health care and sometimes dental care providers) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid)
  - CCOs are focused on prevention and helping people manage chronic conditions, like diabetes using interdisciplinary coordinated care teams in local community settings
  - CCOs features resemble certain features of managed care organizations (MCOs) and Accountable Care Organizations (ACOs)
    - CCOs have an increased focus on local and community integration
  - Required to develop detailed transformation plans addressing:
    - Implementation of an alternative payment model
    - Use of health information technology to promote care coordination
    - Integration of behavioral and primary care via three performance improvement plans

ASSUMING RISK AND BASE PAYMENT FOR CCO SERVICES

- CCOs assume full financial risk (both upside and downside) by using global budgets for the total cost of care which grow at a fixed rate
  - Each CCO integrates all services, including physical, behavioral, and oral health services
- Base payment is through a global budget which has two parts:
  - A capitated per member, per month payment provided monthly by the State
  - A separate per member, per month payment for service not included under the capitation rate
- Oregon Health Authority (OHA) withholds three percent of the monthly global budget to CCOs, putting such funds into a common "quality pool"
  - Pool size increases each year: 2% 2013 (~$47M), 3% 2014 (~$120M)

ALTERNATIVE PAYMENT METHODOLOGY TARGETS: OHA TO CCO'S

- Alternative payments from Oregon Health Authority to CCOs:
  - Dispersed through the CCO "Quality Pool"
    - Potential pool award determined by plan size, all pool funds dispersed each year
  - To earn the full incentive payment, CCOs need to:
    - Meet benchmarks or improvement targets on at least 12 of the 17 incentive measures
    - Meet benchmarks or improvement targets for the Electronic Health Record adoption measure (one of the 12 noted above)
    - Score at least 60% on the PCPCH enrollment measure
  - Challenge Pool funds are those which remain after quality pool funds are distributed
    - Distributed to CCOs that meet benchmark or improvement targets on four measures
      - Alcohol and drug misuse (SBIRT), Diabetes HbA1c poor control, Depression screening and follow-up plan, PCPCH enrollment
    - CCOs have opportunity to earn over 100 percent of maximum quality pool funds

ALTERNATIVE PAYMENT METHODOLOGY TARGETS: CCO'S TO PROVIDERS

- Alternative payments from CCOs to Providers
  - Models and milestones vary amongst CCO's – each has opportunity to develop and implement its own APM via contracts with providers
    - CCOs' Transformation Plans identify actions taken to implement APMs
    - Majority of APMs focus on one type of service or specialty and range from sub-capitation to bundled payments and PCPCH initiatives
  - CCO APMs
    - 13 include pay-for performance; 9 include capitation; 2 mention episodic payments

Table 1. *Key Features of Three CCO Alternative Payment Methodologies*

	Model Features				
CCO	Participating Providers	Capitation[1]	Shared Savings/ Shared Risk	Payment Withholds	Distribution of Payments Based on:
All-Care	PCPs: Josephine County	Yes: PCPs	Yes/No	No	Utilization, access & quality metrics
Eastern Oregon	Optional: Hospitals, PCPs	No	Yes/Yes	Yes: 5% provider withhold	Patient attribution
Central Oregon	Hospital & Physicians	Yes: PCPs & Hospital Services	No/No[2]	Yes: 25% provider withhold on specialists/hospitals	Utilization, process & quality metrics

ALTERNATIVE PAYMENT MODEL GOALS FOR OREGON

- **Goal 1: Reduce Medicaid Statewide Spending Growth**
  - By the end of 2017, State must reduce per capita medical inflation by two percent
    - Will be measured from a 5.4 percent annual projected trend over the course of the demonstration, calculated by Office of Management and Budget
      - Progress measured by reviewing State and Federal costs of purchasing care for individuals enrolled in CCOs
- **Goal 2: Timely and Accurate Data Submission**
  - CMS has a one percent withhold beginning in year 2 (2013) for timely and accurate submission
- **Goal 3: Improve Statewide Care Quality and Access**
  - From 2012-2017, improve access to and quality of care compared to baseline levels
    - Meet or exceed 90th percentile national Medicaid benchmark for ED visit rates
    - Meet or exceed national Medicaid benchmark for all cause readmissions
- **Other: Accountability Milestones, Process Measures, & Self-Evaluation Measures**
  - See next slides

**For full list of quality, access, experience and health goals, visit here (pg.198/385)

OVERALL ACCOUNTABILITY TARGETS AND GOALS

Aim From Driver Diagram	Accountability Milestones, Process Measures, & Self-Evaluation Measures
Improving care coordination at all points in the system, with an emphasis on patient-centered primary care homes (PCPCH)	500 PCPCHs recognized by 2015; 600 by July 2016
	75% of hospitals live on Emergency Department Information Exchange (EDIE) by end of 2014
Integrating physical, behavioral, and oral health care with community health involvement	75% of CCOs and local public health authorities (LPHAs) have OHA-supported collaborative projects on population health by July 2015
	1 percentage point reduction in Medicaid PMPM expenditures by FY 2014, from 2011 baseline; 2 percentage point reduction by FY 2015
Testing, acceleration, and spread of effective delivery system & payment innovations	65% of dual eligibles receive care through CCOs
Testing, acceleration, and spread of effective delivery system & payment innovations	75% of Public Employee Benefit Board (PEBB) lives in plans with Coordinated Care Model (CCM) elements by 2015 plan year
	75% of Oregon Educators Benefit Board (OEBB) lives in plans with Coordinated Care Model (CCM) elements by 2016 plan year
	50% of Qualified Health Plan (QHP) lives in plans with Coordinated Care Model (CCM) elements by 2016 plan year

**Full List of measures is at the end of this presentation or can be found here

HOUSING LINKAGES

- Built around the Triple Aim, multiple counties have interventions underway to address access to affordable housing for Medicaid CCO members
  - This involves implementing health information exchange between network providers
- CCOs are required to partner with county housing, health, and public health agencies to coordinate social and behavioral services for members
  - CCOs may use flexible funds from the global budget for housing supports including:
    - Home and living environment improvements
    - Housing supports related to social determinants of health
    - Shelter, utilities, critical repairs, rental assistance, moving expenses, deposits
  - $30M in general funds awarded by the legislature to CCOs to support innovation
    - Example: CCO chronic disease management program in supported housing
  - Rental Assistance Program Grants
    - Funding housing assistance programs for individuals with serious mental illness

RESULTS AND FINDINGS

- Results
  - Emergency Department visits decreased by 21 percent since 2011
  - Beneficiaries with diabetes and COPD reduced hospital admissions by 9 and 48 percent respectively
  - Inpatient and outpatient costs declined (but PCP and Rx increased)
  - Mixed improvement for many measures, including follow-up after hospitalization for MI
  - Other key results here
- Findings
  - Major barrier is implementing multiple complex initiatives simultaneously without adequate support and funding – need more granular data on members and costs
  - CCOs need more time for strategic planning and want more guidance from OHA in determining payment models – want to move away from encounter data as basis
  - Community advisory council is a major improvement in member engagement

SUMMARY

- Oregon and Minnesota are leading the way for payment and care delivery innovation
- Considerable flexibility is left to the states in order to meet the state-specific vision and target population
- Alternative payment methodology implementation is a main focus of cost-reduction efforts and requires significant planning and flexibility in implementation
- Assumption of risk and associated shared savings rewards are keystones of innovative payment reform programs
- Using target measures, benchmarks, and streamlined data reporting allow for more accurate projections of patient costs and, in turn, improved planning and increased savings

MINNESOTA & OREGON: BACKGROUND INFORMATION

MINNESOTA: ACCOUNTABLE HEALTH MODEL – MEDICAID SHARED SAVINGS AND RISK ARRANGEMENTS

INITIAL MODEL: HENNEPIN HEALTH

- Safety Net ACO (non-profit) consisting of a partnership of four county agencies – Uses a “MCO/Provider Hybrid ACO” model
  - The Hennepin County Human Services and Public Health Department, the Hennepin County Medical Center, the Metropolitan Health Plan, and the NorthPoint Health & Wellness Center
  - 30 percent of Hennepin Health members face housing instability or are homeless
  - Uses a Medicaid capitated structure and "tiering system" for matching people to the most appropriate types of clinical care at different levels
- Based on Hennepin’s successes, State solicited bids to expand the Medicaid ACO demonstration
  - Six other accountable care organizations became operational in January 2013 plus three more in the following year
  - As of June 2015, the IHP demonstration has 16 providers covering over 200,000 enrollees

IHP GOVERNANCE

- IHPs are accountable for health outcomes of the population they serve.
  - Minnesota used initial ACO experiences to make subsequent changes to the program
  - Minnesota's IHPs are awarded bonus points if they include community/social services
    - Payments to community organizations, local public health entities, and/or behavioral health and long-term care providers are within the total cost of care (TCOC) calculation for eligible patients.
    - Such organizations participate in distribution of shared savings and loss payments
- Minnesota Medicaid provided financial and utilization data to each participating organization about the population for which it can expect to be held accountable
  - Based on the state's patient-attribution algorithm
  - IHPs must provide the full scope of primary care, centered around state-certified health care homes or comparable primary care sites

ROLE OF MCO

- Managed Care Organizations (MCOs) under contract with DHS participate in IHPs starting in 2013
  - State does all TCOC calculations and contracting with providers; MCOs will receive data on patients in IHP and their allocated portion of shared savings or losses payment
- MCOs can still have alternative payment arrangements with providers
  - MCOs are incentivized to innovate and implement such payment models to accrue larger shared savings and improve health for their members
  - Aligns payment levels for IHP providers across fee-for-service and managed care
- Current Examples of Flexible Model Plan/Provider Partnerships
  - Traditional ACOs: sub-capitation for all services with ACO risk and gain sharing, and downstream gain sharing with LTC providers
  - Health Care Homes (HCH): Primary care & care coordination PMPM risk/gain sharing
  - HCH/Rehabilitation Facility Combo: PMPM with P4P for primary care and supports

ACCOUNTABLE COMMUNITIES FOR HEALTH (ACH)

- 14 percent of MN's SIM funds ($5.6 million) are dedicated to 15 ACH grants
  - Coordinate care among 180 clinical & social service providers for over 100,000 people
- ACH: Locally planned and led models that bring together community partners to integrate service delivery
  - Communities identify a target population—people in geographic area, a patient population, or a segment of a community—with substantial health and social needs
  - Community partners use formal business agreements to integrate services through:
    - Enhanced referrals
    - Transitions management
    - Implementation of new practice guidelines
  - To meet each ACH's population-specific needs, ACH composition of partners varies
- Builds on existing models of IHPs, community care teams, and health homes to direct networks towards local interventions and care management

SHARED SAVINGS AND DATA SHARING

- Shared Savings
  - Amount that occurs after the conclusion of a demonstration Performance Period based on the most complete data available at that time.
    - Interim Payments not affected by IHP performance on quality and patient experience measures
  - State and its MCOs will pay portions of shared savings to IHPs or share in losses
    - Creates incentives for MCOs to work with providers to achieve cost savings
- Data Sharing and Reporting
  - According to regulation, the hospitals and physician clinics participating in the program must send the state the data necessary to calculate quality performance.
  - Contractually, MCOs must submit data to the Minnesota's Department of Human Services, which manages its claims data in a state-run warehouse, and provides a monthly risk adjustment reports to the IHPs.
    - The data contain both fee-for-service and MCO encounter claims data.

SHARED SAVINGS METHODOLOGY

» *A percentage of the Final Payment is affected by IHP performance on quality and patient experience measures.*

An IHP provider's assigned patients, population risk score, and average per member per month costs are determined for the base year using retrospective fee-for-service claims and MCO encounter data for 2012.

Base year average per member per month costs are adjusted for expected cost trends between 2012 and 2013, as well as changes in the IHP provider's population risk score for 2013, to determine a "Target TCOC" for 2013.

A "Performance Period TCOC" is determined by calculating average per member per month costs for the IHP provider's assigned patients in 2013.

The IHP provider's Target TCOC and Performance Period TCOC for 2013 are compared for purposes of determining performance results and shared savings/risk payments. DHS will make interim payments in the spring of 2014, with final payments made in spring 2015.

OREGON: STATEWIDE COORDINATED CARE ORGANIZATION (CCO) PROGRAM

CCO GOVERNANCE

- CCOs are accountable for health outcomes of the population they serve.
  - They are governed by a partnership among health care providers, community members, and stakeholders in the health systems that have financial responsibility and risk.
  - CCOs must convene a community advisory council (CAC)
    - Includes representatives from the community as well as representatives from local government entities, but with consumers making up the majority of the CAC
  - CCOs have contractual requirements to develop detailed transformation plans addressing:
    - Eight elements of transformation, including implementing at least one alternative payment model (APM)
    - Using HIT to promote care coordination, and
    - Implementing three performance improvement plans focusing on integrating behavioral and primary care

QUANTITATIVE MEASURES, TARGETS, AND GOALS

- Oregon Health Authority (OHA) tracks CCO performance on:
  - 33 state performance metrics (also known as quality and access metrics). OHA is accountable to the Center for Medicare and Medicaid Services (CMS) for statewide performance on these metrics.
    - 16 of these comprise the 17 CCO incentive measures (if CCO meets or surpasses the benchmark, it gets payments from the quality pool – methodology here)
    - 2015 Full list of measures here; most recent report findings with benchmarks and performance rates here
- To meet benchmarks and receive quality pool funding, some CCOs may choose to implement system changes:
  - Registries to improve population health monitoring
  - New processes for claims submission to ensure that services being provided are accurately recorded

EXAMPLES OF MEASURES, TARGETS, AND GOALS

DC State Innovation Model

» Examples of core performance measures and benchmarks

Measure	Description	2014 Benchmark	2014 State Performance	Notes
Screening for alcohol or other substance misuse (SBIRT)	Percentage of adult members (ages 18+) who had appropriate screening and intervention	13%	Improved from 2.0% (‘13) to 7.3% (‘14)	Screening rates increased for all races / ethnicities; African Americans’ highest
Ambulatory care: emergency department utilization	Rate of visits to an ED reported per 1,000 member months - lower = more appropriate use	44.6	Improved from 50.5/1,000 (‘13) to 47.3/1000 (‘14)	Variation by race/ethnicity African Americans have highest rates, Asians lowest
Follow-up after hospitalization for mental illness	Percentage of members (ages 6+) who received a follow-up within seven days of hospital discharge for mental illness.	68.8%	Declined slightly from 67.6% (‘13) to 66.7% (‘14)	Varied among the three reportable races and ethnicities, with no clear pattern emerging
Tobacco use prevalence	Percentage of adult Medicaid members (ages 18+) who currently smoke or use tobacco	25%	Decreased from 34.1% (’13) to 33.0% (’14”)	Medicaid tobacco use higher than general population; increased for Hispanics, Asians

ACCOUNTABILITY TARGET MEASURES FOR OREGON (1)

» The following is a complete list of Accountability Measures for Oregon's Medicaid transformation to CCOs

Aim or Driver from Driver Diagram	Accountability Milestones, Process Measures, & Self-Evaluation Measures
Implementing alternative payment methodologies to focus on value and pay for improved outcomes	**Accountability Milestones**
	Each Coordinated Care Organization (CCO) will test at least one primary care and one non-primary care alternative payment methodology
	Each Public Employee Benefits Board (PEBB) plan will test at least one primary care and one non-primary care alternative payment methodology
	Oregon will adopt a methodology and benchmark for sustainable rate of health care cost growth by 2016
	Process Measures
	Number of alternative payment arrangements put in place by working with major payers or providers; to the extent we are aware of these efforts
	Proportion of CCO plan payments and CCO payments to providers that are non-FFS
	Proportion of PEBB service payments that are non-FFS

ACCOUNTABILITY TARGET MEASURES FOR OREGON (2)

Aim or Driver from Driver Diagram	Accountability Milestones, Process Measures, & Self-Evaluation Measures
Improving care coordination at all points in the system, with an emphasis on patient-centered primary care homes (PCPCH)	**Accountability Milestones**
	500 PCPCHs recognized by 2015; 600 by July 2016
	Goal for training health care interpreters
	75% of hospitals live on Emergency Department Information Exchange (EDIE) by end of 2014
	Process Measures
	Number of individuals receiving care through recognized PCPCHs
	Number of Oregon providers who have ever received an incentive payment through Medicare or Medicaid EHR incentive program, by provider type
	Percentage of PCPCHs that have achieved meaningful use
	Number of users of CareAccord direct secure messaging
	Self-Evaluation Measures
	Number of traditional health workers certified in Oregon
	The Department of Human Service's Adult & People with Disabilities Division and the Area Agencies on Aging Long Term Services and Supports (LTSS) Innovator Agents must create Memoranda of Understanding with local CCOs to ensure LTSS are coordinated with the CCOs

ACCOUNTABILITY TARGET MEASURES FOR OREGON (3)

Aim or Driver from Driver Diagram	Accountability Milestones, Process Measures, & Self-Evaluation Measures
Integrating physical, behavioral, and oral health care with community health involvement	**Accountability Milestones**
	75% of CCOs and local public health authorities (LPHAs) have OHA-supported collaborative projects on population health by July 2015
	Process Measures
	Information on community health or prevention initiatives implemented
	Number of CCOs registered to access local population health data via the Oregon Public Health Assessment Tool (OPHAT)
	Number of Regional Health Equity Coalitions implemented
	Self-Evaluation Measures
	1 percentage point reduction in Medicaid PMPM expenditures by FY 2014, from 2011 baseline; 2 percentage point reduction by FY 2015
	Medicaid quality and access should be maintained or improved even while reducing the state's PMPM cost trend

ACCOUNTABILITY TARGET MEASURES FOR OREGON (4)

Aim or Driver from Driver Diagram	Accountability Milestones, Process Measures, & Self-Evaluation Measures
Testing, acceleration, and spread of effective delivery system & payment innovations	**Accountability Milestones**
	65% of dual eligibles receive care through CCOs
	75% of Public Employee Benefit Board (PEBB) lives in plans with Coordinated Care Model (CCM) elements by 2015 plan year
	75% of Oregon Educators Benefit Board (OEBB) lives in plans with Coordinated Care Model (CCM) elements by 2016 plan year
	50% of Qualified Health Plan (QHP) lives in plans with Coordinated Care Model (CCM) elements by 2016 plan year
	Cross-payer multi-data source dashboard with interactive functionality available at the end of the project period (autumn 2016)
	Process Measures
	Number of Learning Collaboratives established
	Number of Learning Collaborative/quality improvement sessions held
	Average number of participants in Learning Collaboratives or QI events
	Selected evaluation results from Learning Collaboratives or QI events
	Approximate # of Oregonians and percent of population covered by Coordinated Care Model

ACCOUNTABILITY TARGET MEASURES FOR OREGON (5)

Aim or Driver from Driver Diagram	Accountability Milestones, Process Measures, & Self-Evaluation Measures
Cross-cutting	**Process Measures**
	Evaluation results as available from specific initiatives (e.g., congregate housing pilot project, Regional Health Equity Coalitions, etc.)
	Percentage of Oregon community HIEs connected to CareAccord for interoperable direct secure messaging
	Legislative policies, plans, or levers put in place to support health system transformation

GLOBAL FINANCING PROMOTES CCO FLEXIBILITY IN IMPLEMENTING ALTERNATIVE PAYMENT MODELS

- CCOs have the flexibility to support new models of care and payment that are patient-centered and team-focused
  - Development and successful implementation of APMs
    - Solid underlying foundation of relationships built on mutual trust and local-level decision-making
  - CCOs who successfully implemented APMs spent 1-3 years working on models
    - Years of community stakeholders working collaboratively on other projects, or after dedicating significant energy toward building long-term relationships
- Examples
  - Payment composed of baseline funding for primary care, a primary care innovation seed fund, a shared savings program, support for advanced primary care, and an integrated primary care global budget
  - Process for paying PCPs for the quality of care with three elements: panel access, utilization (ED use), and quality based incentive measures.